HEALTH CARE PROVIDER CERTIFICATION OF EMPLOYEE'S FAMILY MEMBER SERIOUS ILLNESS - FMLA

Employee's name John Doe

Patient's name

Relationship to employee ☑ Spouse ☐ Parent ☐ Child (under age 18 or if older and incapable of self care due to a mental or physical disability)

Description of serious health condition *(On the back of this form is the description* of a *"serious health* condition" *under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must* relate *only* to the serious *health condition for which* the *current need for leave exists.*

☐ (1) ☐ (2) ☐ (3) ☑ (4) ☐ (5) ☐ (6) ☐ None of the above

Describe the medical facts and/or treatment that meet the criteria of the category checked above (Medical **diagnosis/prognosis** is not required).

Gastrointestinal disorder that causes abdominal pain, back pain, nausea, diarrhea, painful breathing and fatigue that will incapacitate the patient on an intermittent basis.

Date condition commenced: : 9-5-09 Probable duration of condition: Lifetime

Probable duration of present Incapacity (if different): : give date the employee was absence from work include sdo if in conjunction

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ☑ Yes ☐ No

If no, would the employee's presence to provide psychological comfort be beneficial to the patient's recovery?

Note the probable duration of the need. : if employee has appointment list it

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment of the family member's serious health condition (e.g. follow-up treatment)? ☑ Yes ☐ No

If so, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:
Dates:

Duration: hour(s) or 1 to 2 day(s) per episode.

Period of Recovery: To be re-evaluated in 12 months.

Will the employee require leave on an Intermittent or reduced schedule basis for the family member's serious health condition, that may result In unforeseeable episodes of incapacity (e.g. flare ups)? ☑ Yes ☐ No

If so, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: 1 to 2 times per 1 week(s), month(s):

Duration: hour(s) or 1to 2 day(s) per episode.

If the employee requires leave on an Intermittent or reduced schedule basis to care for a covered family member with a serious Health condition, briefly explain why such care is medically necessary (this can include assisting in the family member's recovery).

Health Care Provider's Name {Please print): Dr. John Well

Health Care Provider's Signature: Date:

Address:

Phone number: Fax number:

Specialty/Type of Practice: May Provide Business Card